

PACIFICARE DENTAL AND VISION ADMINISTRATORS
ATTENDING DENTIST'S STATEMENT AND CLAIM FORM
for predetermination of benefits and reimbursement for actual services performed



It's important to complete this form fully!
Your claim will be paid faster

JUST FOLLOW THE INSTRUCTIONS BELOW:

First, check the one box that indicates the type of claim you are filing:

If you are submitting this form for a predetermination of benefits over \$1200, check the box marked DENTIST'S PRETREATMENT ESTIMATE.

If you are submitting this form in order to claim payment for services already rendered, check the box marked DENTIST'S STATEMENT OF ACTUAL SERVICES.

Then complete the entire form, following the instructions for each box number:

1. Please print or type in patient's full name: first, middle, last.
2. Place an X in the box that describes the patient's relationship with the County Employee Participant: self, spouse, child, or other.
3. Place an X in the box that describes the patient's gender: male or female.
4. Enter the patient's birthdate: month, day, and year.
5. Please enter the County Employee participant's name: first, middle, last.
6. Enter the County Employee participant's ID Number here.
7. Enter the County Employee participant's full mailing address, including city, state, and zip code.
8. The name of the group dental program is Dental 861.
9. The Employer (Company) name and address is County of Orange, P.O. Box 25191, Santa Ana, CA 92799-5191.
10. The Group ID number is 102055.
11. Enter the city in which the employer providing coverage is located. This would be the location at which the County Employee participant is based.
12. Enter the name of any family member employed, other than the County Employee participant or the patient.
13. Enter the name and address of that family member's employer.
14. If the patient is not covered by another dental plan, enter NO. If the patient is covered by another dental plan, write YES and give the plan name, the union local (if applicable), the group number, and the name and address of the carrier providing dental coverage.
15. Enter the full name of the attending dentist.
16. Enter the attending dentist's mailing address, including city, state, and zip code.
17. Enter the attending dentist's federal tax ID number.
18. Enter the attending dentist's license number.
19. Enter the attending dentist's area code and telephone number.
20. Enter the first date on which services claimed on this form were provided.
21. Make an X in the box that best describes the place of treatment: dental office, hospital, emergency care facility, or other.
22. Are X-rays enclosed with this form? If so, mark YES and indicate how many. If not, mark NO.
23. Is the dental treatment described on this form the result of an occupational illness or injury? If not, mark NO. But if it is, mark YES and indicate the nature of the illness or injury and the date it occurred.
24. Is the dental treatment described on this form the result of an automobile accident? If not, mark NO. But if it is, mark YES and indicate the nature of the accident and the date it occurred.
25. Is the dental treatment described on this form the result of an accident of any other kind? If not, mark NO. But if it is, mark YES and indicate the nature of the accident and the date it occurred.
26. Are any of the dental services described on this form covered by another plan? If not, mark NO. But if any are, mark YES and indicate which ones.
27. If a prosthesis, such as a denture, is described in this form, is this the initial placement? If it is, mark YES. But if the prosthesis is replacing an existing appliance, mark NO and briefly indicate the reason for replacing it.
28. If you answered NO to #27, indicate the date when the prior placement occurred.
29. Are any of the dental services described in this form for orthodontic treatment? If not, mark NO. But if they are, mark YES and indicate the date when the orthodontic treatment program began and how many more months are remaining.
30. Describe the dental services this form represents. When appropriate, list them on a tooth-by-tooth basis. In numerical order, by tooth number, list:
 - Tooth Number
 - Tooth Surface
 - Name or Description of Procedure (use more than one line, if needed)
 - Date the Procedure was Performed
 - The American Dental Association (ADA) Code for the Procedure
 - The Attending Dentist's Fee for the Procedure

Refer to the full mouth chart on the left, noting tooth numbers and marking any missing teeth with an X.
31. List any additional remarks that are necessary in describing an unusual procedure or course of action.

ATTENDING DENTIST'S STATEMENT



CHECK ONE:

- ☐ DENTIST'S PRETREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

PACIFICARE DENTAL AND VISION ADMINISTRATORS
P.O. BOX 25191 • SANTA ANA, CA 92799-5191
1-800-591-5915

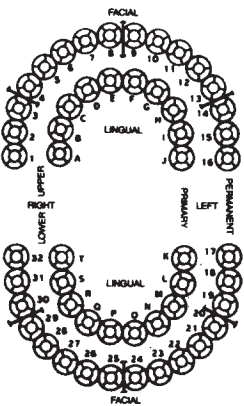
1. PATIENT NAME		2. RELATIONSHIP TO PARTICIPANT SELF SPOUSE CHILD OTHER		3. SEX M F		4. PATIENT BIRTHDATE MO DAY YEAR	
5. PARTICIPANT (COUNTY EMPLOYEE) NAME FIRST MIDDLE LAST			6. PARTICIPANT SOCIAL SECURITY #		8. NAME OF GROUP DENTAL PROGRAM DENTAL 861 - COUNTY OF ORANGE		
7. PARTICIPANT MAILING ADDRESS				9. EMPLOYER (COMPANY) NAME AND ADDRESS COUNTY OF ORANGE			
CITY, STATE, ZIP				P.O. BOX 25191 • SANTA ANA, CA 92799-5191			
10. GROUP NO. 102055		11. LOCATION (LOCAL)		12. ARE OTHER FAMILY MEMBERS EMPLOYED? NAME(S)		13. NAME AND ADDRESS OF EMPLOYER IN ITEM 12	
14. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?		DENTAL PLAN NAME		UNION LOCAL		GROUP NO.	
						NAME AND ADDRESS OF CARRIER	

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (PATIENT, OR PARENT IF MINOR)		DATE		SIGNED (PARTICIPANT)		DATE	
15. DENTIST NAME		23. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO		YES	
16. MAILING ADDRESS		24. IS TREATMENT RESULT OF AUTO ACCIDENT?		NO		YES	
CITY, STATE, ZIP		25. OTHER ACCIDENT?		NO		YES	
17. DENTIST TAX ID NO.		18. DENTIST LIC. NO.		19. DENTIST PHONE NO.		26. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	
20. FIRST VISIT DATE CURRENT SERIES		21. PLACE OF TREATMENT OFFICE HOSP ECF OTHER		22. RADIOGRAPHS OR MODELS ENCLOSED?		27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	
28. DATE OF PRIOR PLACEMENT		29. IS TREATMENT FOR ORTHODONTICS?		NO		YES	
IF SERVICES ALREADY COMMENCED ENTER		DATE APPLIANCES PLACED		MOS. TREATMENT REMAINING?			

IDENTIFY MISSING TEETH WITH AN "X"



30. EXAMINATION AND TREATMENT PLAN. LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32 - USE CHARTING SYSTEM SHOWN							FOR ADMINISTRATIVE USE ONLY	
TOOTH # OR LET.	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO. DAY YEAR			PROCEDURE NUMBER	FEE	
		1						
		2						
		3						
		4						
		5						
		6						
		7						
		8						
		9						
		10						
		11						
		12						
		13						
		14						
		15						
		16						
		17						
		18						
		19						
		20						

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST)

DATE

TOTAL FEE CHARGED

MAX. ALLOWABLE

DEDUCTIBLE

CARRIER PAYS

PATIENT PAYS